Integrative Medicine

Pediatric Intake

Dear Caregiver,

Thank you for taking the time to fill out this questionnaire. It is extensive, but history plays a vital role in Integrative Medicine, so your time and accuracy in filling out this document will allow me to best serve your child, you, and your family.

If your child is old enough, please ask them to participate in filling out the form, particularly the REVIEW OF SYMPTOMS. For areas that do not apply, please put "N/A" rather than leave them blank. If there is something that you do not know or are unclear about, please let me know by placing a question mark by that item.

Please bring all medication and supplements your child is taking or a picture of the label with the dose/ingredients to the appointment. Also, bring any laboratory tests, other types of studies, and vaccine records.

Please bring the above documents, the completed questionnaire, and a three-day diet diary to the appointment.

During the first appointment, we will gather information and possibly order tests. At the second appointment, we will review the diagnosis, test results, and recommendations. You will be provided with a printed copy of the recommendations. Depending on the findings, more appointments may be needed to evaluate progress and adjust the treatment

If you have any questions, please call the office. I look forward to working together in this journey.

Sincerely,

Ana Tanase MD, FAAP, ABOIM, FAIHM

GENERAL INFORMATION

Name: _____
First *Middle* *Last*

Preferred Name: _____ Date of Birth: _____ Age:_____

Gender: ☐ Male ☐ Female

Genetic Background: ☐ African ☐ European ☐ Native American ☐ Mediterranean

☐ Asian ☐ Ashkenazi ☐ Middle Eastern ☐_____

Mother's/Guardian Name:_____Occupation: _____

Father's/Guardian Name:_____Occupation: _____

Home Phone_____Work Phone_____

Mother's Cell Phone:_____Father's Cell Phone: _____

Fax: _____ Email: _____

Emergency Contact

Name: _____Phone: _____

Address:_____

City, State, Zip:_____

Physician

Name:_____Phone: _____

Fax: _____

Referred by:

☐ Website ☐ Media ☐ Friend/Family Member ☐ Other_____

Insurance:

☐ AHCCCS ☐ Private

COMPLAINTS/CONCERNS

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Excellent	Good	Fair

What do you hope to achieve in your visit? _____

_____

If you had a magic wand and could help your child in three ways, what would they be? (GOALS)

1._____

2._____

3._____

When the last time you felt your child was well? (ONSET of problem)_____

Did something trigger your child's change in health?_____

_____

Is there anything that makes your child feel worse?_____

Is there anything that makes your child feel better?_____

Has your child tried complementary, integrative or alternative therapies in the past? ◻ Yes ◻ No

Name of therapy	For what condition	Duration of therapy	Improvement seen
			◻ Yes ◻ No
			◻ Yes ◻ No
			◻ Yes ◻ No

PAST MEDICAL HISTORY (check what applies)

Past	Current	
		MUSCULOSKELETAL/PAIN
		Fibromyalgia
		Chronic Pain
		Scoliosis
		Broken bones
		SKIN DISEASES
		Eczema
		Rashes
		Acne
		Other
		GENITAL AND URINARY
		Kidney Stones
		Urinary Tract Infections
		Yeast Infections
		Bedwetting
		GASTROINTESTINAL
		Irritable Bowel Syndrome
		Constipation
		Crohn's / Ulcerative Colitis
		GERD (reflux)
		Celiac Disease
		Other
		CARDIOVASCULAR
		Congenital heart disease
		High cholesterol
		Fainting/dizziness
		Heart murmur
		Irregular heart rate
		RESPIRATORY DISEASES/ENT
		Frequent Ear Infections
		Chronic cough
		Asthma
		Chronic Sinusitis
		Sleep Apnea
		Other
		INFLAMMATORY/AUTOIMMUNE
		Chronic Fatigue Syndrome
		Autoimmune Disease
		Rheumatoid Arthritis

Past	Current	Immune Deficiency Disease
		Frequent infections
		Food Allergies
		Environmental Allergies
		Multiple Chemical Sensitivities
		Vaccine reactions
		PANDAs
		Valley fever
		Cancer
		Other
		METABOLIC/ENDOCRINE
		Diabetes
		Prediabetes
		Hypoglycemia
		Thyroid problems
		Polycystic Ovarian Syndrome (PCOS)
		Weight Gain or loss
		Early/ late sexual development
		NEUROLOGIC
		Vision problems/glasses
		Hearing problem
		Headaches
		Cerebral palsy
		Low/High muscle tone
		Mild Cognitive Impairment
		Delays in development
		Seizures
		Concussions
		Other Neurological Problems
		MOOD/BEHAVIOR
		Depression
		Anxiety
		ADD/ADHD
		Sensory Integrative Disorder
		Autism/ Austin spectrum
		Down syndrome
		Genetic problems

HOSPITALIZATIONS ☐ None

Age	Reason

PREVIOUS EVALUATIONS *(provide dates)*

Date	
	Blood Tests
	Genetic Evaluation
	Neurological Evaluations
	EEG or qEEG
	Gastroenterology Evaluations
	Evaluation for learning disability
	Allergy Evaluation
	Auditory Evaluation
	Vision Evaluation
	Physical Therapy
	Occupational Therapy
	Speech Therapy
	Sensory Integration Therapy
	Chiropractic
	MRI
	CT Scan
	Upper Endoscopy
	Upper GI Series
	Ultrasound
	Other alternative therapies
	Other specialists seen

SURGERIES

Age	
	Appendectomy
	CIrcumcision
	Hernia
	Tonsils
	Adenoids
	Detal Surgery
	Tubes in Ears
	Other

IMMUNIZATIONS

☐ Up to date
☐ Partially immunized
☐ Vaccines declined

DENTAL HISTORY

☐ Child has cavities now or in the past
☐ Mercury fillings ☐ Root Canals
☐ Tooth pain ☐ Bleeding gums ☐ Dental caps
☐ Gingivitis ☐ Chewing problems
Does child floss regularly? ☐Yes ☐No

MEDICAL SYMPTOM QUESTIONNAIRE

BASED ON THE PAST 30 DAYS rate each of the following symptoms based on your child's health profile.
Mark numbers 0-4 next to each item based on the following scale:

0. Never or almost never 1. Occasionally have it, effect not severe 2. Occasionally have it, effect is severe

3. Frequently have it, effect not severe 4. Frequently have it, effect is severe

Joints/Muscles	**Scale**
Pain or aches in joints	
Stiffness or limitation of movement	
Pain or aches in muscles	
Muscle weakness, tiredness	
Total	
Skin	**Scale**
Acne	
Hives, rashes, eczema, dry skin	
Hair loss	
Excessive sweating	
Total	
Genitourinary	**Scale**
Frequent/urgent urination	
Genital itch or discharge	
Total	
Digestive	**Scale**
Nausea or vomiting	
Diarrhea	
Constipation	
Bloating	
Passing gas/ belching	
Heartburn	
Abdominal pain	
Total	
Weight	**Scale**
Excessive eating/drinking	
Craving certain foods	
Excessive weight	
Underweight	
Compulsive eating	
Total	

Lungs	**Scale**
Chest congestion	
Asthma/bronchitis	
Difficult breathing	
Chronic cough	
Total	
Heart	**Scale**
Irregular heartbeat	
Rapid or pounding heartbeat	
Chest pain	
Total	
Mouth	**Scale**
Gagging, throat clearing	
Sore throat, hoarse voice	
Swollen/discolored tongue, gums, lips	
Canker sores	
Total	
Nose	**Scale**
Stuffy nose/ excessive mucous	
Sinus problems	
Nose allergies/ sneezing	
Frequent infections	
Nose bleeding	
Total	
Ears	**Scale**
Ear infections/pain	
Itchy ears	
Drainage from ear	
Ringing in ear/ hearing loss	
Total	
Eyes	**Scale**
Watery or itchy eyes	
Swollen, red or sticky eyelids	

Dark circles under eyes	
Blurry vision (does not include near of far sightedness	
Total	
Head	**Scale**
Headache	
Fainting	
Dizziness	
Insomnia	
Total	
Mind	**Scale**
Poor concentration	
Poor understanding, confusion	
Poor memory	
Poor physical coordination	
Difficulty making decisions	
Speech problems	
Learning disabilities	
Total	
Emotions	**Scale**
Mood swings	
Anxiety, fear or nervousness	
Anger irritability or aggressiveness	
Depression/ sadness	
Obsessions/ compulsions	
Total	
Energy/Activity	**Scale**
Hyperactivity	
Sluggish/ fatigue	
Restlessness	
Apathy, lethargy	
Total	

Grand Total_____

Key: Total score less than 10 – optimal; 10-50 – mild toxicity; ; 50-100 – moderate toxicity; Over 100 severe toxicity

FAMILY HISTORY

	Check biological family members that apply.	Mother	Father	Brother(s)	Sister(s)	Other
Skin	Eczema / Psoriasis					
Genito urinary	Kidney stones, kidney disease					
	Frequent urinary infections					
Gastro intestinal	Inflammatory Bowel Disease/ irritable bowel					
	Celiac Disease (Wheat Sensitivity)					
	Food Allergies, Sensitivities or Intolerances					
	Gallbladder disease					
	Hepatitis/ Liver problems					
Cardiovascular	High Cholesterol					
	High blood pressure					
	Heart Disease/Heart attack					
Respiratory	Asthma/ Lung problems					
Metabolic	Obesity					
	PCOS					
Endocrine	Diabetes					
	Thyroid problems					
	Stroke					
Inflammatory, immune	Inflammatory Arthritis (rheumatoid, Psoriatic, Ankylosing Spondylitis, Lupus)					
	Environmental Sensitivities					
	Chronic fatigue/ Fibromyalgia					
Neuro	Migraines/ Headaches					
	Multiple Sclerosis					
	Seizures/ neurologic problems					
Psychiatric Disorders	Substance Abuse (alcohol, drugs)					
	Anxiety					
	Depression					
	Schizophrenia, Autism					
	ADHD/ADD					
	Bipolar Disease					
	Learning problems,					
Other	Anemia/sickle cell					
	Genetic Disorders					
	Cancers					
	Deceased					
	OTHER Family Diseases: (list below)					

MEDICATIONS/ SUPPLEMENTS

Current Medications ◘ **None**

Medication	Dose	Frequency	Start Date (month/year)	Reason for Use

Previous Medications: *Last 7 years (attach list if appropriate)*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

Nutritional Supplements (Vitamins/Minerals/Herbs/Homeopathy) □ **None**

Supplement and Brand	Dose	Frequency	Start Date (month/year)	Reason for Use

Allergies

Medication/Supplement/Food	Reaction

Has there been prolonged use of anti-inflammatory medication (Advil, Motrin, Aspirin etc.)? ☐Yes ☐No

Has there been prolonged use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)? ☐Yes ☐No

Frequent antibiotics > 3 times/year ☐Yes ☐No

Used antifungal, anti-parasitic medication ☐Yes ☐No

Use of steroids (prednisone, nasal/asthma allergy inhalers) in the past ☐Yes ☐No

Use of oral contraceptives ☐Yes ☐No

Has your child taken antidepressants, antipsychotics, stimulants or ADHD medication before? (If yes, how many times?)

Name of Medicine	Month/Year Taken	Condition	Dosage and Length of Treatment

PATIENT BIRTH HISTORY

Mother's Past Pregnancies

Number of pregnancies _____ Live Births _____ Miscarriages _____

Mother's Pregnancy

- ☐ Difficulty getting pregnant (more than 6 months)
- ☐ Infertility drugs used
  Type_____
- ☐ In vitro fertilization
- ☐ Drink alcohol
- ☐ Drink coffee
- ☐ Smoke tobacco
- ☐ Take antibiotics
- ☐ Take antibiotics during labor
  Type_____
- ☐ Take other drugs
  Type_____
- ☐ Have a viral infection
  Type_____
- ☐ Have a yeast infection
- ☐ Have physical or emotional trauma
- ☐ Medication during pregnancy
  Type_____
- ☐ Have birth problems
- ☐ Group B strep infection
- ☐ Have C-section
  Reason_____
- ☐ Use induction for labor (such as Pitocin)
- ☐ Have anesthesia
  Type_____
- ☐ Have an x-ray
- ☐ Gestational Diabetes
- ☐ High blood pressure (pre-eclampsia)
- ☐ Postpartum depression
- ☐ Have chemical exposure
  Type_____
- ☐ Move to a newly built house
- ☐ House painted indoors/outdoors
- ☐ House exterminated for insects
- ☐ Other_____
  _____

PERINATAL

Pregnancy duration: *How many weeks of gestation?*_____ Weight at birth:_____lbs. ___oz.

Hospital/Birthing Center? ☐Yes ☐No
Needed Newborn Special Care / NICU? ☐Yes ☐No
Easily consoled during first month? ☐Yes ☐No
Suffered from colic or reflux ☐Yes ☐No

BREASTFED HISTORY

Breastfed? ☐Yes ☐No

Exclusively breastfed for how many months? _____

BOTTLEFED HISTORY

Bottle fed? ☐Yes ☐No Type of formula?
Introduction to cow's milk at what age?
Introduction to solid foods at what age?
Choke/Gas/Vomit on milk? ☐Yes ☐No

Please describe any other eating concerns that you have regarding your child:_____

_____

EARLY CHILDHOOD ILLNESSES

Number of earaches in the first two years? _____
Number of other infections in the first two years? _____
How many course of antibiotics in the first two years? _____

First antibiotic at _____ months

Vaccine reactions: _____

Constipation or digestive issues:_____

_____

DEVELOPMENTAL PROBLEMS

☐ None

If your child has developmental problems, at what age did they occur?	_____
Choose from the following three scenarios:	
Your child hit milestones and spoke on time, then abruptly changed and was "lost".	☐Yes ☐No
Your child never hit milestones and did not speak on time.	☐Yes ☐No
Your child was developing normally, then hit a plateau (no abrupt change)	☐Yes ☐No

GYNECOLOGIC HISTORY *(For female patients ONLY)*

Menstrual History

Age at first period: _____ Menses frequency: _____ Length: _____

Pain: ☐Yes ☐ No Clotting: ☐Yes ☐ No

Regular periods? ☐Yes ☐ No Last period: _____

Use of hormonal contraception such as ☐birth control pills ☐patch ☐implantable ☐IUD

Length of time: _____

NUTRITIONAL HISTORY/ DIGESTION

Is your child following a special diet or does he or she have specific dietary limitations or needs based on health, ethnic, cultural, or religious preferences? ☐Yes ☐ No

Please explain:_____

☐Organic foods ☐Partially organic foods ☐Non organic foods ☐Canned or farmed fish

Does your child avoid any particular foods? ☐Yes ☐No

If yes, what types and reason: _____

If your child could pick his/her favorite foods per day what would that be? What are his/her food cravings?

_____

Who does the shopping in your household? _____

Who is involved in preparing food for and feeding your child? Check all that apply.

☐Self ☐other parent ☐school ☐daycare ☐in-home care ☐grandparent

Which of the following beverages does your child drink and how cups per day may?

☐Water_____ ☐milk_____ ☐milk alternative_____ ☐juice_____ ☐soda/diet soda_____ ☐Other _____

How many meals does your child eat out per week? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐More than 5 meals per week

How many meals per day does your child eat _____ How many snacks per day_____

Check all the factors that apply to your current lifestyle and eating habits:

- ▢ Low fruit / vegetable intake
- ▢ High sugar / sweets intake
- ▢ Caffeine intake / caffeinated drinks
- ▢ Fast eater
- ▢ Erratic eating patterns
- ▢ Eats too much
- ▢ Poor snack choices
- ▢ Sensory issues with food
- ▢ Picky eater
- ▢ Processed foods
- ▢ Limited variety of foods <5/day
- ▢ Every meal is a struggle
- ▢ Most family meals together
- ▢ Use food as a bribe or reward
- ▢ Most meals eaten at the table
- ▢ TV or videos with meals
- ▢ Eating late at night
- ▢ Eating for comfort

DIGESTION

How many stools per day does child have _____

Are your child's stools	☐Hard	☐Large	☐Pebble like	☐Require straining?
	☐Soft	☐Loose	☐Watery	☐Alternating diarrhea/constipation
Gas?	▢Often	▢Sometimes	▢Rarely	
Bloating?	▢Often	▢Sometimes	▢Rarely	
Stomach Pain?	▢Often	▢Sometimes	▢Rarely	
Nausea/Vomiting?	▢Often	▢Sometimes	▢Rarely	

LIFESTYLE

SLEEP/REST

Average number of hours your child sleeps per night: _____

Does your child have trouble falling asleep? ▢Yes ▢No

Trouble staying asleep? ▢Yes ▢No

Does your child feel rested upon awakening? ▢Yes ▢No

Does your child snore? ▢Yes ▢No

Takes medicine for sleep ▢Yes ▢No

ACTIVITY

How much time does your child spend watching TV? _____

How much time does your child spend on the computer or playing videogames? _____

How much time does your child spend outside per day?_____

▢Daily ▢ Few times per week ▢Weekly ▢Less than weekly

How often does your child read or how often does someone read to your child?_____

Child enrolled in sports ☐Yes ☐No

Activity		Frequency	

RISK

Does anyone in your child's household smoke?	☐Yes	☐No
Has your child been exposed to or used street drugs or alcohol?	☐Yes	☐No
Are there guns in the house?	☐Yes	☐No

PSYCHOSOCIAL

Has your child experienced any major life changes that may haveimpacted his/her health?

_____

Has your child ever experienced any major losses/trauma? (please detail)

_____

Has your child ever been abused, a victim of a crime, or experienced a significant trauma?

_____

STRESS/COPING

Does your child have a favorite toy or object?_____

What are your child hobbies and interests? _____

What are your child favorite activities?_____

Check all that apply: ☐Yoga ☐Meditation ☐ Imagery ☐Breathing ☐Tai Chi ☐Prayer ☐Other:_____

Does your child feel stressed? ☐Yes ☐No Stress sources: ☐ family ☐school ☐health

Do you feel stressed? ☐Yes ☐No

Resources for emotional support for you and child*:*

❑Family ❑Friends ❑Religious/Spiritual Pets ❑Other: _____

LEARNING

Child attends ❑public school ❑charter school ❑home schooling

How is your child's academic performance? ❑in gifted program ❑straight A's ❑average

❑failing classes ❑Has IEP plan ❑is in special education ❑has 504 plan

Behavior problems in school? ❑Yes ❑No Is it easy to make friends? ❑Yes ❑No

SOCIAL SITUATION

List family members living in the house:

Name of Family Member and Relationship	**Age**	**Occupation**

Pets in the house _____ In how many homes does child live?_____

SOME THINGS ABOUT *PATIENT'S* PARENTS

When were parents married:_____ If separated, when: _____

If divorced, when:_____ If remarried, when: _____

Custody arrangements: _____

MOTHER - PERSONAL		**FATHER - PERSONAL**	
Age at childbirth	_____	Age at childbirth	_____
Education	_____	Education	_____
Ethnicity	_____	Ethnicity	_____

ENVIRONMENTAL HISTORY

Please check appropriate box (INCLUDE DATES)

Past	Current	None	Date	
☐	☐	☐		Mold in bathroom
☐	☐	☐		Mold visible on exterior of house
☐	☐	☐		Mold in school/daycare
☐	☐	☐		Pest extermination
☐	☐	☐		Close to area treated with herbicides, fungicides, pesticides (golf course, agricultural area)
☐	☐	☐		Use well water
☐	☐	☐		Live in new house
☐	☐	☐		House built prior to 1978
☐	☐	☐		Carpet in bedroom
☐	☐	☐		Pet dander
☐	☐	☐		Feather or down bedding

READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing). – circle what applies

In order to improve your child's health, how willing are you /the child to do the following?:

Educate yourself about the child's conditions	5 4 3 2 1
Significantly modifying diet	5 4 3 2 1
Taking several nutritional supplements each day	5 4 3 2 1
Modifying lifestyle (e.g., work demands, sleep habits)	5 4 3 2 1
Practicing a relaxation technique	5 4 3 2 1
Engaging in regular exercise	5 4 3 2 1
Have periodic lab tests to assess progress	5 4 3 2 1
See other specialists (therapists, acupuncture)	5 4 3 2 1

Comments_____

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? Rate on a scale of: 5 (very supportive) to 1 (very unsupportive) 5 4 3 2 1

Comments_____